EMAIL ADDRESS: _____

Athlete ID or Social Security #	APPLICATION FOR ATHLETE PARTICIPATION IN SPECIAL OLYMPICS	Please check appropriate box:
Male _____ Female_____		☐ Special Olympics Athlete
Date of Birth_____/_____/_____		☐ Unified Teammate / Partner
Height_____Weight_____	COUNTY School or Agency	

Name of Athlete:	Day Phone Number: ( )	Evening Phone Number: ( )
Address:	City:	State: Zip:
Parent or Guardian:	Day Phone Number: ( )	Evening Phone Number: ( )
Address:	City:	State: Zip:

EMERGENCY INFORMATION

Emergency Contact Person:	Day Phone Number: ( )	Evening Phone Number: ( )
Address:	City:	State: Zip:

HEALTH AND ACCIDENT INSURANCE INFORMATION

Company Name:
(Athletes without insurance, write NONE) Policy Number:

HEALTH INFORMATION

Please Circle Appropriate:

Down Syndrome	YES	NO	Fainting Spells	YES	NO
Atlanto-axial instability Evaluation by X-ray	YES	NO	Heat illness or Cold Injury	YES	NO
(circle YES for positive, NO for negative			Hernia or Absence of 1 Testicle	YES	NO
and NONE for no X-Ray available)	NONE		Recent Contagious Disease or Hepatitis	YES	NO
			Kidney problems or loss of function		
HISTORY OF			in one kidney	YES	NO
Diabetes	YES	NO	Pregnancy	YES	NO
Heart Problems	YES	NO	Bone or Joint problems	YES	NO
Seizures	YES	NO	Contact Lens / Glasses	YES	NO
Legally Blind	YES	NO	Dentures / False Teeth	YES	NO
Vision problems and/or less than 20/20			Emotional problems	YES	NO
vision in one or both eyes	YES	NO	Special Diet needs	YES	NO
Legally Deaf	YES	NO	Asthma	YES	NO
Hearing Aid / Hearing problems	YES	NO	High / Low Blood Pressure	YES	NO
Requires Wheelchair	YES	NO	Other		
Motor impariment requiring special equipment	YES	NO			
Non-Verbal Individual	YES	NO	Blood Pressure: _____/_____	Pulse:_____	
Bleeding Problem	YES	NO			

COMMENTS - **SEE BACK**

MEDICATIONS

Medication Name:	Amount:	Time:	Date Prescribed:

Allergies to Medication:

IMMUNIZATIONS

Tetanus: Yes No Date of Last Tetanus Shot: Polio: Yes No

Signature of Person Who Completed Health Information (Normally signed by Parent, Guardian or Adult Athlete)

SIGNATURE: **DATE:**

IF THERE IS ANY SIGNIFICANT CHANGE IN THE ATHLETE'S HEALTH, THE ATHLETE'S CONDITION SHOULD BE REVEIWED BY A PHYSICIAN BEFORE FURTHER PARTICIPATION

MEDICAL CERTIFICATION

NOTICE TO PHYSICIAN: If the athlete has Down Syndrome, Special Olympics requires that the athlete have a full radiological examination establishing the absence of Atlanto-axial Instability before he/she may participate in sports or events which, by their nature, may result in hyper-extension, radical flexion or direct pressure on the neck or upper spine The sports and events for which such a radiological examination is required are equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing and soccer.

CHECK::: ☐ I have reviewed the above health information and examined the named in the application, and certify there is no medical evidence available to me which would preclude the athlete's participation in Special Olympics..

THIS CERTIFICATON IS VALID UP TO 3 YEARS

Athlete Restrictions:			
Physician's Name:		Phone Number ( )	
Address:	City:	State:	Zip:
PHYSICIAN'S SIGNATURE:		DATE:	

Created by The Joseph P. Kennedy, Jr. Foundation

MUST BE SIGNED BY MD, DO, CRNP, FNP or PA

MD/DO Comments: _____

_____

_____

_____

RELEASE TO BE COMPLETED BY ADULT ATHLETE

I, _____ am at least 18 years old and have submitted the attached application for participation in Special Olympics.

I represent and warrant that, to the best of my knowledge and belief, I am physically and mentally able to participate in Special Olympics activities. I also represent that a licensed physician has reviewed the health information contained in my application and has cetified, based on an independent medical examination, that there is no medical evidence which would preclude me from participating in Special Olympics. I under stand that if I have Down Syndrome, I cannot participate in sports or events which by their nature result in hyper-extension, radical flexion or direct pressure on my neck or upper spsine unless I have had a full radiological examination which establishes the absence of Atlanto-axial Instability. I am aware that I must have this radiological examination before I can participate in equestrian sports, gymnastics, diving, pentathlon, butterfly stroke, diving starts in swimming, high jump, alpine skiing, and soccer.

Special Olympics has my permission, both during and anytime after, to use my likenes, name, voice, or words in either television, radio, film, newspapers, magazines, and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.

If, during my participating in Special Olympics activities, I should need emergency medical treatment, and I am not able to give my consent or make my own arrangements for that treatment because of my injuries, I authorize Special Olympics to take whatever measures are necessary to protect my health and well-being, including, if necessary, hospitaliztion.

I, the athlete named above, have read this paper and fully understand the provisions of th release that I am signing. I understand that by signing this paper, I am saying that I agree to the provisions of this release.

Signature of Adult Athlete_____ Date _____/_____/_____

I hereby certify that I have reviewed this release with the athlete whose signature appears above. I am satisfied based on that review that the athlete understands this release and has agreed to its terms.

Name (**Print**): _____

Relationship to Athlete _____

RELEASE TO BE COMPLETED BY PARENT OR GUARDIAN OF A MINOR ATHLETE

I am the parent/guardian of _____, a minor athlete, on whose behalf I have submitted the attached application for participation in Special Olympics. I hereby represent that the athlete has my permission to participate in Special Olympics activities.

I further represent and warrant that to the best of my knowledge and belief, the athlete is physically and mentally able to participate in Special Olympics activities. With my approval, a licensed physician has reviewed the health information set forth in the athlete's particiapation. I understand that if the athlete has Down Syndrome, he/she cannot participate in sports or events which by their nature result in hyper-extension, radical flexion or direct pressure on the neck or upper spine, unless a full radiological examination is required are equestrian sports, gymnastics, diving, pentathlon, butterfly stoke,diving starts in swimming, high jump, alpine skiing, and soccer.

In permitting the athlete to participate, I am specificlly granting my permission, (both during and anytime after), to Special Olympics to use the athlete's likeness, name,m voice and words in television, radio, film, newspapers, magazines and other media, and in any form, for the purpose of advertising or communicating the purposes and activities of Special Olympics and/or applying for funds to support those purposes and activities.

If a medical emergency should arise during the athlete's participation in any Special Olympics activities, at a time when I am not personally present so as to be consulted regarding the athlete's care, I hereby authorize Special Olympics, on my behalf, to take whatever measures are necessary to ensure that the athlete is provided with any emergency medical treatment, including hospitalization, which Special Olympics deems advisable in order to protect the athlete's health and well-being.

I am the parent (guardian) of the athlete named in this application. I have read and fully understand the provisions of the above release, and have explained these provisions to the athlete. Through my signature on this release form, I am agreeing to the above provisions on my own behalf and on the behalf of the athlete named above.

I hereby give my permission for the athlete named above to participate in Special Olympics games, recreation programs, and physical activities programs.

Signature of parent/guardian_____ Date_____/_____/_____

RETURN COMPLETED, SIGNED FORM TO YOUR LOCAL PROGRAM